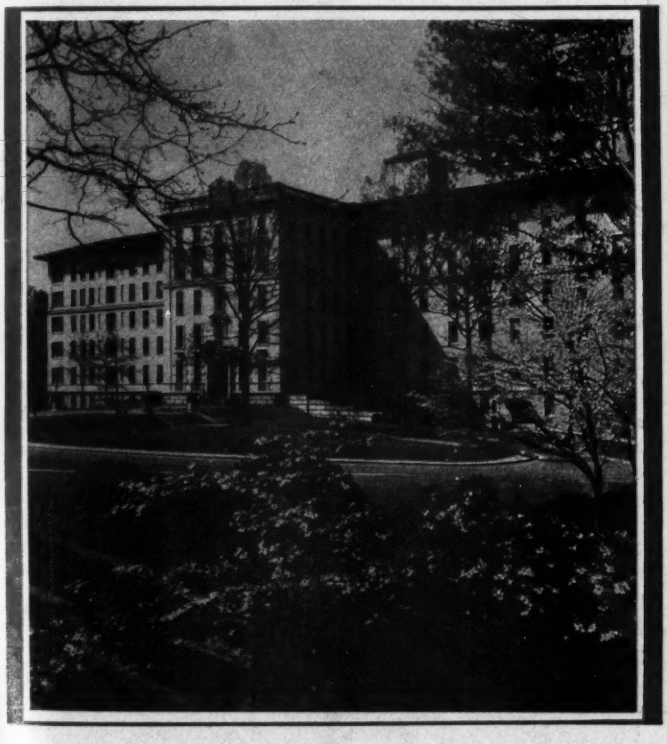
Oral Hygiene

FEBRUARY 1952



Emory University Hospital, Atlanta, Georgia. The Thomas P. Hinman Mid-Winter Clinic convenes in Atlanta, March 23-26.

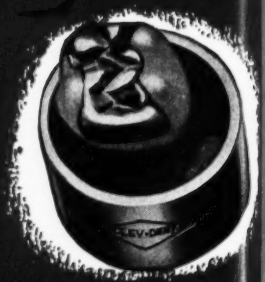
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Fees That Are Fair To Your Patient And You

THE PNEUMATIC CONDENSER



FOR DENSER GOLD FOIL AND AMALGAM FILLINGS



ADDITIONAL INFORMATION ON REQUEST

THE *Cleveland* DENTAL MANUFACTURING CO.

CLEVELAND, OHIO U.S.A.

VOL. 42, NO. 2 **Oral Hygiene** FEBRUARY 1952

REGISTERED IN U. S. PATENT OFFICE

Circulation more than 73,000 copies monthly

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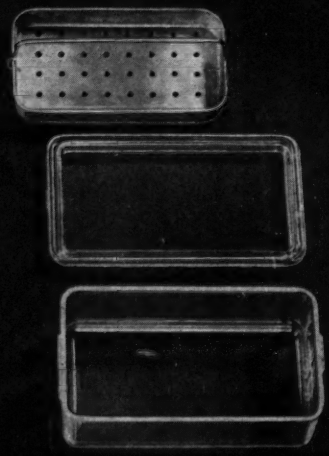
Picture of the Month



DOCTOR Ora R. Rice, Delavan, Wisconsin, dentist, was elected to the Assembly of the State Legislature in 1936. Since that time, he has served continuously on important legislative committees and as Chairman of the State Centennial Committee. Previously he served as alderman and then as Mayor of Delavan for one term. Doctor Rice was elected Speaker of the Wisconsin State Assembly for the 1951 session.—*Black Photo, submitted by Doctor Ewald C. Wetzel, 2522 E. Capitol Drive, Milwaukee, Wisconsin.*

Ten dollars will be paid for the picture submitted and used in this department each month. Send glossy prints with return postage to ORAL HYGIENE, 708 *Church Street, Evanston, Illinois.*

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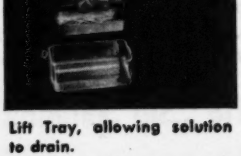
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How the Cold-Sterilization Unit Works



Here is complete Unit. Remove cover and place upsidedown next to Container



Lift Tray, allowing solution to drain.



Place Tray in inverted C Select Kerr Carbex Bu work at hand.

Malpractice Is Big Business

BY DOUGLAS W. STEPHENS, D.D.S.

By taking every precaution necessary, you can curtail your share of damage suits involving dentistry.

LAST YEAR the Southern California Superior Courts awarded over five million dollars to plaintiffs in civil action cases. In the same courts malpractice suits filed against dentists for that year amounted to around eight hundred thousand dollars. Win, lose, or draw, these suits cost dentists a great deal of money. And the sorriest part of it all is that most of these dental suits could have been avoided.

Why, then, were these cases in court? Is dentistry getting less skillful in its treatment of the human race? Of course not. Dentists are more skillful and better trained than ever before in the history of the profession. But why all these malpractice suits?

One reason is because suing has turned into a big-money racket involving millions of dollars every year. When that much money is involved, it becomes a tough, dirty business.

People sue at the drop of a hat and that is not necessarily a figure of speech. One man sued his neighbor because the neighbor's hat blew off and hit him in the face while he was driving his car, causing him to run into a telephone pole. People sue when they slip on the floor of the dentist's office. They sue when they fall over his children's toys or when the dentist's car bumps a fender.

They sue for three main reasons: greed, malice, and revenge.

Top insurance men say the public is more claim-conscious than ever before. When Mr. Average Citizen opens his evening paper,

he reads about his neighbor, Mrs. Jones, receiving $50,000 for the loss of an eye or someone else getting $5,000 for an injured finger. It looks like easy money and the first time something happens to him, Mr. A. Citizen sues too. If his memory needs jogging, thousands of attorneys will jump at the chance.

How can we stop this vicious inroad to our private lives and fortunes? We can't—entirely—but we *can* prevent a large number of malpractice cases by observing certain precautions in our own offices, and by carrying ample insurance to cover all possible disputes.

Refuse Difficult Patients

One thing every dentist should learn is that there are certain patients he should not accept for treatment. Whenever a patient tells you he has been to several other dentists and these fellow practitioners have not been able to fit his mouth or treat him satisfactorily, beware. If he tells you he has sued another dentist or if he displays obvious neurotic tendencies, he is not for you. As soon as you realize you are dealing with this type of patient, for your own protection, politely usher him out of your office. For, once he has tasted the golden flavors at the court of law and has found them good, he may desire another snack.

Use clear and understandable history charts. Poor records lose cases in court. Find out whether patients coming in for extraction have seen their physicians in the last year. Ask if they are subject to profuse bleeding, nervous disorders, fainting, or dizziness. Are they sensitive or allergic to any drug? Have they any history of heart trouble, diabetes, asthma, tuberculosis, kidney or liver involvement, or any other constitutional disorders? Have they shown any unfavorable reaction from previous dental treatment?

Insist they sign a card on which this data is given. It costs little to have them printed. Data like this will not win malpractice suits, but it may help. At any rate, it will guide you in your treatment and aid you in giving better service.

Never extract teeth for a minor without the consent of his parents. And it is best to have it in writing. If you do not, they can sue you for assault to the child and for a lot of other misdemeanors you never heard of before.

Take roentgenograms and keep them on file. Do not give them to a patient if you have treated him, especially if you have extracted any teeth. The patient has not bought the roentgenograms from you as material things. He has paid you for your time and knowledge in giving a complete diagnosis of his mouth. Roentgenograms are one of your aids to better dentistry. Like your mouth mirror which sees the outer third of a tooth, the roentgenogram shows the hidden two-thirds.

Be careful of escharotic drugs. Phenol, silver nitrate, phenylsulfuric acid, aromatic sulfuric acid, and many others of the caustic type have been used as a basis for malpractice cases.

Use non-slip wax on your floors and little of that. Install temperature control devices on your impression material heating baths. Test every piece of impression material that goes into the mouth to be sure it will not burn the patient. Watch that handpiece. See that it is engaged securely so it will not drop on the patient. Many suits have resulted from falling handpieces, one involving the death of a patient.

Do not leave sharp pointed instruments on the tray in front of child patients. Children have a habit of reaching for these and may be cut. Never operate when you are overly tired. Look twice before extracting—better still, have a roentgenogram of every tooth you are to remove and consult it a moment before you place the forceps on the tooth. Extraction of the wrong tooth is a common complaint in malpractice cases.

Never sue a patient for a fee until the statute of limitations has expired. In most states this is a year and a day. The patient may countersue and come up with a trumped-up malpractice charge costing you more than the amount of your bill. When giving an account to your attorney or collecting agency for collection, have it in writing that you do not want the case brought to suit unless you give them written instructions to do so.

A short time ago, an orthodontist called an exodontist on the telephone and asked him to remove the "two upper number-four teeth." The orthodontist was from one school and intended to indicate the right and left upper first bicuspids. The exodontist was from another school that taught a different system of numbering teeth. He thought the orthodontist meant to extract the upper four bicuspids. This he proceeded to do and a law suit resulted.

Until the profession standardizes the numbering of the teeth, only use a number system within your own office. However, when giving directions to anyone outside, designate the specific teeth by name. Say the upper right and left first bicuspids instead of number 5 and 12 or 4 and 4. It takes a little longer, but there will be fewer mistakes.

Above all, do not take risks. If you cannot perform a particular operation, send your patient to someone who can. Your patient will thank you in the end. Performing an operation you are not trained to do may bring about a malpractice suit. Even if you are heavily insured, do not take a chance. It is a nice feeling to know the insurance company will back you if you lose, but it still costs

(*Continued on page* 207)



Connecticut dentist describes the "Operation Greenhouse" experiment at Eniwetok.

BY VICTOR J. KLUBEK, D.D.S.

AFTER ENDLESS hours of flight over the Pacific, a group including myself saw the dim outlines of the Pacific atoll known as Eniwetok—the testing grounds used by the Atomic Energy Commission for the observation of atomic power. My assignment was resident dentist to care for the dental needs of men stationed on this secret atoll.

Upon my arrival at the base hospital and dental clinic, I was amazed at the fine equipment and supplies available, for our nearest medical depot was Los Angeles, which is over twelve days by ship from our base. General health and sanitary conditions on the entire atoll were excellent. It was particularly interesting to observe that all drinking and bathing water was distilled from the ocean by means of a large distillation plant. A project such as this could not have functioned without such a plant for, at the height of the tests, enough water was demanded to serve all the needs of 8,000 men.

This enormous atomic project was labeled Operation Greenhouse. The hospital and dental clinic were located at base headquarters on a separate island where all scientists —Army, Navy, and civilian—made their home. Here, under the direction of Doctor A. Graves and General Quesada, USAF, all the planning and administration of the tests took place. From here the phy-

sician and the dentist were flown to other islands to administer to the needs of men working on various phases of the project. Trips to other islands could be made either by air or water, but for definite reasons air travel was preferred.

At the base clinic all types of dentistry were performed. Lacerated lips and fractured teeth due to on-the-job accidents were common. The X-ray machine used in the clinic was invaluable but, due to climatic conditions, we always had a penetration of moisture around the tube causing frequent shorts in the circuit. This was remedied by keeping the head of the X-ray covered with plastic material with a 100-watt bulb enclosed and lighted continuously. All postoperative cases took a little longer to heal, and bleeding after extraction was more common than it is in the United States. But, again this was due to climatic conditions.

International Dentistry

The dental health of all patients on the testing grounds was excellent. The majority of the men on this project had done overseas construction work most of their lives. For instance, a patient would come to the clinic for a routine examination. One would be told that the patient's bridgework was done in South America, restorations in Alaska, dentures in Saudi Arabia. I must stress here that dental service was performed only on male patients, for under no conditions were women allowed to enter the testing grounds.

During the entire phase of Operation Greenhouse, the medical research team worked night and day. Many outstanding mathematicians were a part of this research team and their mathematical computations proved invaluable during the entire testing period. It was my good fortune to associate with these brilliant men and to hear the interesting lecture by General Cooney of the Army Medical Corps on the type of burns to expect and the importance of evacuation during atomic attack. Evacuation from the area of radiation will save thousands who would die needlessly otherwise. The importance of having hospitals or first-aid stations prepared to handle the large number of casualties that could result from an atomic attack should be stressed. Few cities have enough hospital beds to take care of even 500 emergency cases, yet we must speak in the thousands.

The dental profession has an important part to play in this type of emergency, and the physician, dentist, and nurse can fill even a greater role as a team in case such a crisis should arise. The dentist would be able to assist in the first-aid treatment of patients suffering from burns, lacerations, fractures, and shock. We, as dentists, should refresh our minds in the techniques of administering blood, plasma, and other types of intravenous injections. The evacuation of patients

in the exposed radiatized area can be undertaken five minutes after the initial blast. The crater caused by the atomic blast will be dangerous and, under no circumstances, should it be entered until it is checked hours and maybe days later by people trained in this type of work. I am speaking of evacuating people from the perimeter of the crater back. An untold number of lives would be saved in this manner.

The establishment of first-aid stations will be our biggest problem. Not so long ago, in one of our largest cities, a few hundred casualties resulted from a nightclub fire and the hospital facilities were totally inadequate to cope with the emergency. Yet, if an atomic bomb should fall, the casualties would not be in the hundreds but thousands. It *can* happen and, if it does, dentists should be among the first to render all assistance possible to those less fortunate.

White Clothing Protects

It was interesting to learn that, among the dogs and pigs used during the atomic tests at Eniwetok, the animals with spotted coats received the deepest burns, while those with white coats received lesser burns; and the casualties among the dogs and pigs having all-white coats were rare. White clothing gives the finest protection against atomic radiation. In Hiroshima, women wearing colored dresses with various patterns such as flowers received burns that embedded the entire pattern on their bodies.

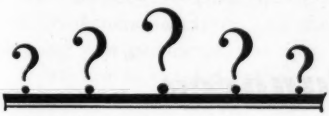
All animals used in these tests were anesthetized prior to exposure to radiation and I have seen a number of animals being evacuated from the radiatized area hours later and still slumbering peacefully. All animals were handled with the greatest care and consideration.

Extensive medical investigation was made by scientists and research men during this series of tests and the results will be released to the public in the near future. We owe much to these men and especially to General Quesada and Doctor Graves, who were in charge of the operation. Men from all walks of life helped to make this project a success, and I am sure they will be long remembered.

The islands offered various forms of recreation, the most popular being shell hunting and fishing. The capture of a shark was always a thrilling sight. Open air movies were held nightly, rain or shine. Lectures by outstanding men of science were given weekly and enjoyed by all. It was with genuine regret that many of us bid Aloha to this onetime paradise atoll.

241 *Griswold Drive*
West Hartford, Connecticut

So You Know Something About DENTISTRY!



QUIZ LXXXIX

1. For dental amalgam alloy, the U. S. Bureau of Standards calls for a minimum of (a) 52, (b) 65, (c) 76, per cent silver. _____

2. What does one seek when a chronic skin fistula is noted? _____

3. Disto-occlusion usually exhibits (a) general shortness of the face, (b) an undereruption of bicuspids and molars. _____

4. True or false? Carbide burs and diamond points can be used dry but they cut more rapidly under a water spray. _____

5. With the mouth wide open, the size of the buccal space is (a) increased, (b) decreased, (c) unchanged. _____

6. Why is careful interproximal examination of deciduous molars difficult? _____

7. Most oral infections are (a) endogenous (organisms introduced from inside the mouth), (b) exogenous (organisms introduced from outside the mouth). _____

8. Can mouth breathing produce gingivitis? _____

9. True or false? The general use of mouth washes can be considered to serve no more intrinsic purpose than as an aid in the removal of loose food and debris. _____

10. Is the electric pulp tester reliable in a tooth with a putrescent pulp where there is moisture in the canal resulting from decomposition? _____

FOR CORRECT ANSWERS SEE PAGE 228



Fluoridation: Neither Poison Nor Panacea

BY NORMAN R. JOFFEE, D.D.S.

IF THERE is an argument against the fluoridation of municipal water supplies, it will have to be better than the one advanced by Doctor Swendiman in ORAL HYGIENE.[1] The case against fluoridation, as he presents it, is so full of holes it makes a sponge seem nonporous. And, just as a sponge may be cut apart, so may the contentions which Doctor Swendiman advances. Let us examine the argument point by point.

A. *Fluorides are both corrosive enough to etch glass and toxic enough to be an ingredient of rat poison.*

True, but a water solution of one part of fluoride per million will do neither. Let us not lose sight of the fact that there is always a difference between the therapeutic dosage and the toxic dosage of *any* drug.

B. *Who will guarantee that the addition of the prescribed amount of fluoride to the water will not produce some far-reaching, even delayed, systemic disorders?*

Nobody will. However, be mindful of the many endemic areas where such an amount of fluoride occurs naturally. The insurance actuarial statistics for persons living in such areas are the same as elsewhere. Apparently the only effects of prolonged drinking of such water are that the incidence of caries is lower, and that a small percentage of people have mottled enamel.

C. *Since it has long been known*

[1]Swendiman, G. A.: The Argument Against Fluoridating City Water, ORAL HYGIENE 41:1256-1267 (September) 1951.

Illinois dentist refutes stand of North Dakotan in municipal water system controversy.

that a diet containing large amounts of free sugar is a cariogenic diet, let us attack the problem at its source. Instead of battling fluoride therapy, let us actively combat the confectioners, soft drink manufacturers, and the chewing-gum producers.

If we are to combat caries actively, why throw away one perfectly good weapon? Fluoridation of water supplies will reduce the incidence of dental caries, and we know it! Let us continue to use that weapon. As for carrying the attack directly to the manufacturers of confections, such a course can do no harm. With few exceptions, practicing dentists today tell their patients of the dangers of a high sugar diet. A more concentrated campaign of this sort could be carried to the public by the public relations staff of the American Dental Association, and such a course would be simply one more weapon to use against caries.

It is a matter of minute concern that our educational efforts might incur the wrath of a few soft drink manufacturers; if the fight were carried to the public, we would whip them hands down. But even the most intensive efforts along those lines would not justify our jettisoning the program that is set up for supplementing municipal water supplies with fluorides. Anyone who remembers the Volstead Act must realize that the consumption of any type of food or beverage cannot be restricted through legislation. And, no matter how thoroughly we educate the public, still there will be those who find that a coke refreshes and a candy bar provides some quickly utilizable energy. It is possible to provide such people with some measure of protection by fortifying their water supplies with fluorides.

D. *Fluoridation of water supplies is a socialized measure, leading to more government bureaus, governmental intervention in the private practice of dentistry, and all its attending evils.*

This sounds terrifying, and it would be if it were true. However, this is not even a half-truth! I can speak only for the State of Illinois where only three regulations must be complied with in order to install a municipal fluoridation program. (Notice that we have already bypassed the federal government which has no jurisdiction in the matter.) The three regulations are:

1. The municipality (notice that we are now down to the local government level) must pass an ordinance or resolution indicating the public's decision (which implies a direct referendum) to fluoridate the public water supply, submitting a copy to the Illinois Department of Public Health.

2. Evidence of approval of fluoridation by *local* medical and den-

tal groups must be submitted to the Illinois Department of Public Health. (Does it still sound as if governmental bureaucracy is in the driver's seat?)

3. Because the Illinois Department of Public Health *already* has statutory jurisdiction over public water supplies, engineering plans and specifications must be approved by that department prior to installation of fluoridation equipment. This precaution prevents economy-minded municipal governments from making inadequate installations.

E. *The fluorides are an experimental type of medicine and, as such, they should not be applied to any large segment of the population. To quote Doctor Swendiman, "When I want water, I want water; I don't want any socialistic bureau to decide that some dubious medicine must be forced down my throat at the same time."*

Well! First of all, let us be cognizant of the fact that the experimental results are in from many communities. The caries rate for these communities was compared with that of communities which were similar in every respect except for the fluoridation of water; and, in every instance, the rate was much lower in the experimental community than in its corresponding control community. No side reactions that would contraindicate use of fluorides were observed. In view of these facts, fluoride therapy *cannot* be dismissed as one of those "experimental" measures.

As for Doctor Swendiman's desire for "water, and only water," I shudder to think of the typhoid and dysentery epidemics that would occur if the chlorinating of the municipal water supplies were abandoned.

The socialistic bureaus, which this dentist fears, do not exist and it is not likely that fluoridation will create any.

F. *Primitive people, eating primitive diets, have virtually no dental caries. Therefore, why not "compel" people now to refrain from consuming candies, cakes, cookies, and soft drinks? Let us "prohibit, by suitable laws, the manufacture of refined sugar, refined flour, and similar devitaminized atrocities."*

The edible matter which Doctor Swendiman attacks so vigorously certainly cannot be defended on its merits as nourishment. However, much of it does taste good and is in great demand. Should the "suitable" legislation that he suggests be passed, it would take the vast bureaucracy that he so abhors to enforce it. Need I remind you again of the Volstead Act? By now, certainly we should realize that people cannot be compelled to give up anything that they really desire, be it a martini, the right to free speech, or a candy bar!

G. *Instead of using the fluorides, let us actively inform the public as to the evils of sweets and synthetic foods. We cannot leave this job of*

★ ★ ★ ★ ★ ★ ★ ★

ORAL HYGIENE AWARD

This article by NORMAN R. JOFFEE, D.D.S., has won the $100 ORAL HYGIENE award for the best feature published this month.

★ ★ ★ ★ ★ ★ ★ ★

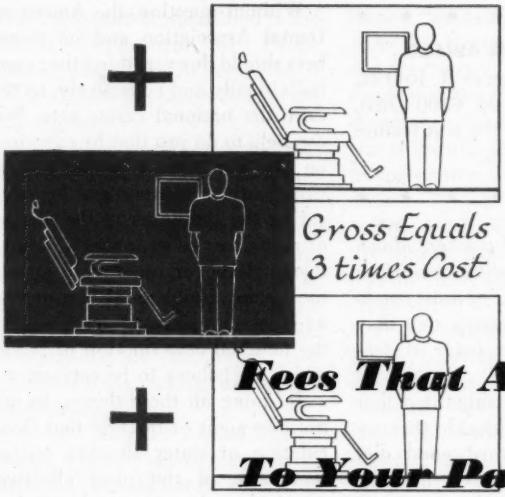
education to school teachers alone, because "the unhealthy conditions found in the mouths of most teachers are a sure indication that they possess meager knowledge of dental health."

It is respectfully submitted that a *combination* of fluoride therapy *and* education toward good diet habits is more effective than the application of either measure alone. It is further submitted that, if a survey were made of the oral pathology of school teachers as a group and the same survey made of dentists as a group, it is probable that the incidence of "unhealthy" conditions would be similar in both groups. After all, teachers have little money for dentistry and dentists have little time available in which to be dental patients. This does not exclude either teachers or dentists from their rightful places in the field of dental education. Remember the late W. C. Fields' advice, "Don't do as I do; do as I tell you to do!"

Without question, the American Dental Association and its members should do everything they can, individually and collectively, to reduce the national caries rate. We can help to do just that by carrying on our own private practices in a conscientious manner and by educating the public as to the causes of dental caries so far as we know them. Moreover, we should attack the caries problem at its source and make a positive effort to reduce the national consumption of foods which we believe to be cariogenic.

In doing all these things, let us not lose sight of the fact that fluoridation of water supplies represents one of the most effective means ever placed in our hands for the reduction of caries. And above all, let us not be misled into believing that the fluoride program is a socialistic, bureaucratic scheme to place the control of private dental practices in the hands of subversive elements. The choice of whether your community is to use the fluorides or not is still in the hands of *your own democratically elected local government.* The program is in definite accord with the American ideal of "the greatest good for the greatest number."

21 *North Sheridan Road*
Highland Park, Illinois



Fees That Are Fair To Your Patient and You

Final installment of article to guide the dentist in stabilizing his practice financially.

BY MEYER M. SILVERMAN, D.D.S.

YOU SHOULD keep in mind one or more of the following three methods for analysis of your gross income to determine whether your practice has a healthy financial foundation, yielding you a fair profit without profiteering.

1. *Gross income must equal total office cost plus living expenses plus savings.* This formula is self-explanatory and must balance. A practice should pay for an office with modern and complete equipment that will help the dentist render his patients the finest type of service dentistry has to offer. The dentist should be able to support and maintain his family in comfort, and he should provide for his old age and emergencies through systematic savings.

2. *Operative dentistry should cover all expenses.* It is advisable that the general practitioner cover all his office and living expenses,

but not necessarily his savings, from his output of operative dentistry. When savings are not covered by operative dentistry, it is necessary that the prosthetic phase of the practice provide this need. This formula should be applied to every practice according to its type of service. The pedodontist must make children's operative dentistry pay for his office, living, and savings expenses. The prosthodontist must do the same with his prosthetics; and the surgeon, the orthodontist, and the periodontist must each apply this principle to his respective field.

3. *Gross income should equal three times the cost per hour of rendering a service.* This three-to-one ratio is ideal and fair to both dentist and patient, but is seldom attained. Instead of expenses being 33 per cent of gross income, frequently they are from 40 to 60 per cent of the gross—the general average. For example, if the cost determination formula shows that it cost you $5 per productive hour in cash from your pocket to operate your office, it is advisable to receive three times that cost, or $15 per productive hour, for operative dentistry in order to receive a fair return.

To determine the cost of prosthetics, total the hourly office cost and the laboratory cost in building a case. The prosthetic fee should be three times this total cost. Nonproductive items such as prophylaxes, roentgenograms, diagnoses, denture adjustments, and other services, including free services, lower the ideal three-to-one ratio until most of us find that about half of our fees go into office expenses and the other half into salary.

If you record time spent on each individual patient, it is simple to compare the number of productive hours spent operating in the individual office to the 1,000-hour national average. A dentist may operate as much as 1,500 productive hours but, in doing so, he risks wearing himself out before his time. Since operative dentistry is generally nonproductive, it is advisable to check on this phase frequently. It is surprising how many services return no more than unskilled day labor, and at times actually *cost* money. If you have recorded the time spent on patients for the entire month or even an entire year, you can check your operative dentistry to find out if you are getting a three-to-one ratio based on the actual number of hours spent on that operative service, regardless of the number of hours per year you spend. To determine your actual return or fee per hour for operative dentistry for the month or even a year: *Divide the number of productive hours used in producing operative dentistry into the operative fees received.* This operative return per hour of actual working time, whether more or less than the normal 1,000-hour yearly average, can

be compared to the cost per hour of operating your office as shown by the cost determination formula. It is interesting to see that few of us receive the three-to-one ratio we need. In a like manner, the return per hour for prosthetics can be determined and then compared to the cost per hour of prosthetics. The cost of prosthetics is determined by totaling the cost of the office time spent on prosthetics and the corresponding laboratory bills. This, too, can be determined on a monthly or even a yearly basis.

Correction of Profiteering

The adjustment of profiteering is important from the point of view of the patient. It is a moral obligation on the part of the dentist to treat his patient fairly and give him value for the fee charged. After all, dentistry is a blind product to the patient and he must place his confidence in his dentist with the expectation that he is receiving value for the fee he is being charged. It is simple to adjust profiteering by one of two methods; either reduce fees or give a better service for the fee charged.

The correction of insufficient return is important to both the dentist and the patient. A dentist can have a busy practice and find that he is unable to enjoy the comfort expected by the average middle-class family, and is pauperized after a lifetime of active practice. When a dentist sees that he is having difficulty meeting his obligations, he will turn out more dentistry in the available working hours. Often this results in inferior dentistry. He must do this in order to make ends meet; then the patient suffers from the high cost of inferior dentistry. Insufficient return can be corrected in any of these three ways:

1. *Raise fees.* It must be remembered that to raise fees the dentist must be prepared to render a service to his patient that is worthy of that fee. The patient always must receive value for his money.

2. *Increase production.* We must find ways and means of turning out better dentistry in less time through efficiency of operation and improved techniques. This can be accomplished through study and attendance at dental meetings and conventions. Unfortunately, many practices will produce a greater quantity of poor dentistry within a shorter period of time in order to make ends meet. This method of correcting insufficient return is not advisable, although it is forced on some dentists by bargain-hunting patients.

3. *Work longer.* This is the case with most of us. In order to make ends meet, we must work more than the normal and sensible average of 200 working days per year or 1,000 productive hours per year. The closer you can regulate your practice to operate your office on a 1,000-productive-hour basis per year, the longer you will live to support your family and serve

the patients who desire your services the most.

The day sheet is the basis on which the author's system is regulated. It is felt that a system separating the generally nonproductive and low-profit operative dentistry from the more lucrative prosthetic dentistry is imperative. By this means, either phase of the practice can be analyzed and an attempt can be made to make the necessary corrections. This day sheet can be tied into any system used in dentistry. Therefore, it is not necessary to cover any of the various records used. All modern patient cards or sheets have time columns in which the time spent on patients as recorded on the day sheet can be transferred to the patient record. From this column, the time spent on the entire completed contract or any particular treatment can be computed to determine the cost of the items in question. Then this can be checked with the fees charged in order to determine whether the three-to-one ratio as mentioned earlier was received or not.

The entries on the day sheet are made by the assistant and compiled daily. The *Time In* and *Out* is recorded to the nearest five minutes, and the total number of minutes recorded under *Minutes Operative* or *Prosthetics*, depending on the nature of the service. Under *Fees Operative* or *Fees Prosthetics* should be entered the charges for the respective services. The author prefers to record the charge in the fee column when the operation such as amalgam, inlay, bridge, or denture, is completed. Some dentists might prefer to record charges for services daily, regardless of completion, and this would include preparations, wax patterns, impressions, and bites. If this latter procedure is preferred, it means breaking down the charges for the various items even further. Regardless of what method you use, it is most advisable to record and total the fees charged for operative dentistry and prosthetic dentistry.

At the end of the day or month you can see the amount of operative and prosthetic dentistry completed in dollar volume, instead of relying on the age-old collection barometer to determine how good business might be. There is no false sense of security when collections are good. There is no fear when collections are bad. Instead of losing money month after month until you are overrun with debts, you can determine immediately whether you must increase your gross through various practice-building methods, raise your fees, cut down on office expenses, reduce your standard of living, or reduce your systematic savings, attacking all these phases either individually or collectively. We should take an example from such businesses as department stores. They determine how good business is by the dollar volume of merchandise sold—not by collections. When sales are

good, business is good. Collection is the business of an upstairs credit department and will take care of itself automatically when handled properly. The dentist should control his practice in a similar manner. He should remember that eventually collections will be dependent on the amount of dentistry turned out of his operating room daily and monthly. It does not matter how many patients are waiting in the reception room, or how far in advance you are booked, or how many patients you see per day, or how much money you happen to collect today. What does matter is how much excellent dentistry in dollar volume you produce daily and monthly.

Summary Sheet

The summary sheet is filled out by the assistant also, and is the compilation of the day sheet totals to furnish the monthly totals of the same information. This sheet can also be used for the annual summary of the day sheet information. This day sheet and summary sheet can be revised to include any practice-building information you might desire.

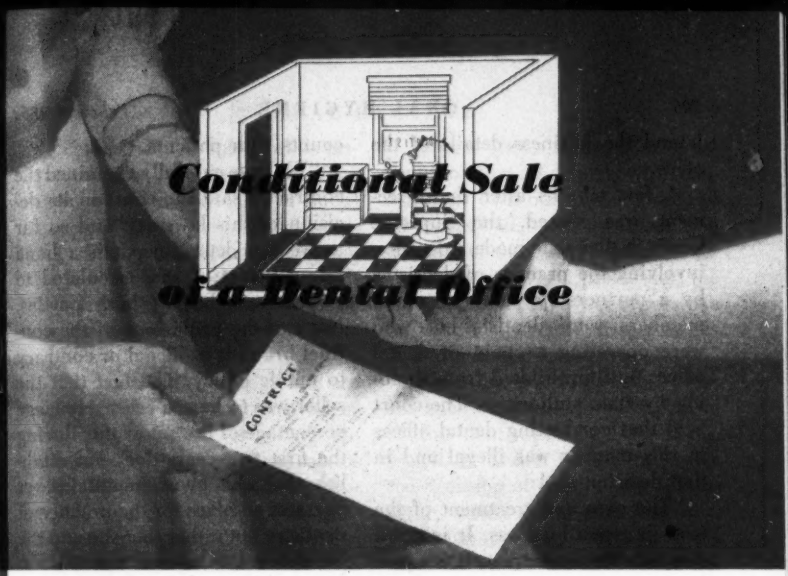
It is immaterial whether this system or a similar system is adopted, but it is necessary that some good method of practice control be used in order to know what it costs to operate your office and to determine adequate fees.

The author's system of separating operative and prosthetic dentistry in order to analyze the respective costs and fees is one which will give you peace of mind and your patients better service. You can determine immediately the financial health of your practice and, in turn, determine a fee that is fair to both you and your patient. It is through such a system as this that you can keep your fees as low as possible with a fair profit to you and preserve your patients' dental health with the finest type of service possible.

3500 *Fourteenth Street, N.W.*
Washington 10, D.C.

THE COVER

OUR COVER this month is a picture of the Emory University Hospital in Atlanta in dogwood time. Dogwood is only one of the spring flowers that will be blooming when the Thomas P. Hinman Mid-Winter Clinic convenes March 23, 24, 25, and 26 in the Municipal Auditorium in Atlanta under the auspices of the Fifth District Dental Society of Georgia.



Conditional Sale of a Dental Office

BY ALBERT WOODRUFF GRAY

A detailed example of the legal disposition of a practice by a dentist's widow.

A DENTIST died in the State of Washington, leaving his widow the problem of disposing of a lucrative practice. She made an agreement with a licensed dentist in which she agreed to sell the fixtures and equipment with the provision that, "The doctor shall spend his whole time in the professional care of the office and shall have exclusive control over the professional conduct and practice in said office."

The purchase price to be paid by the dentist was $36,000 payable in monthly installments of $300 over a period of ten years. These monthly installments were to be deducted from the profits of the office in addition to $750 a month which the dentist should withdraw for living expenses. From the balance, after the payment of these amounts and the current expenses, the widow should receive 70 per cent for the first year, 60 per cent the second, and 55 per cent for the three following years, after which the dentist retained all the net profits.

As the purchaser was unable to pay cash, the agreement provided that the ownership of the fixtures and equipment should remain with the widow until the total purchase price was paid, with the further provision that she should be the manager of the business and super-

intend the business details of the office.

A few months after the agreement was signed, the Supreme Court in that state made a decision involving the practice of dentistry by a partnership, none of whose members were dentists but who were operating a chain of dental offices until prohibited from so doing by state authorities. The court held that conducting dental offices in this manner was illegal and in that decision said:

"The care and treatment of the teeth is not a business. It is not a commercial transaction. It is a profession. A person may own and sell dental equipment and supplies but the state has said, in the exercise of its police power, that he cannot practice dentistry without a license, and that a person practices dentistry who owns, maintains, or operates an office for the practice of dentistry."

After this decision was published, the purchaser wrote the woman with whom he had this agreement that the contract he had made with her was illegal and that he would make no further payments. To this he added, "You are further notified that the books are no longer open to your inspection or approval and you are to remain away except for reasonable inspection of your property."

The buyer supplemented this notice with a lawsuit to recover $7,025 which he claimed represented outstanding and unpaid accounts with patients.

"We have carefully examined the contract," said the court in its decision of this lawsuit, "and so far as we can determine, it is a bona fide contract of sale calculated to protect and benefit both parties. None of the provisions of the contract brand it as illegal or contrary to public policy. The fact that the seller was to have a relatively large percentage of the net profits during the first five years does not establish that she owns, maintains, or operates an office for the practice of dentistry but rather that she and the purchaser had agreed upon a formula for arriving at a value of a going business which we conceive to be the good will of an established dental practice."

The contract recognizes a clear-cut distinction between professional conduct and practice in the office which was to be under the exclusive control of the purchasing dentist, and the business management of the office, which the widow of the late dentist was to superintend.

Business Management Help

It is common knowledge that many physicians and dentists and certainly most clinics leave the details of business management such as the keeping of business records, the issuing of statements, the collection of accounts, and the details of disbursements for supplies and equipment to personnel employed for that purpose.

The particular title of the person

or persons who do this work is immaterial, and whether it be office manager, office secretary, or bookkeeper, we do not regard the handling of those details as constituting the practice of dentistry, although their capable performance may be essential to make that practice profitable.

The fact that the same details are supervised by one who, instead of being an employee, is selling the practice under a conditional sale of contract, does not of necessity constitute such ownership, maintenance, or operation of the practice of medicine or dentistry.

In a protest against the confusion of the courts on the difference between the business management of a dental office and the actual performance of dentistry, a dissenting opinion to the decision in the earlier case relating to the maintenance of a chain of dental offices contains a clear statement of the distinction between these two necessary features of a dental practice.

"There seems to be a tacit assumption that all dentists who manage their own offices are good and all others bad," said this dissenting member of the court, "and that, because dentistry is a profession, the competency of its practitioners can be assured by requirements in addition to licensing.

"From decision to decision, there has been copied a touching picture of the dentist-patient relationship which, if drawn merely to justify the licensing of the practice of dentistry, would have some cogency. Just what it proves with regard to a dentist's private financial affairs and nonprofessional acts, has never been pointed out. Also, its bearing on the ownership or management of property, which is neither a profession nor a necessary incident to any profession, has never been indicated."

3536 *Seventy-Sixth Street*
Jackson Heights, Long Island

MALPRACTICE IS BIG BUSINESS

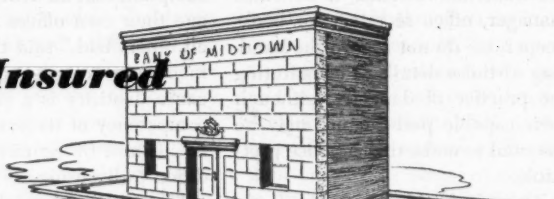
(*Continued from page* 191)

money in lost hours from the office, in worry, and in sleepless nights. And remember that sometimes a suit takes more than the maximum amount of your policy. Then it really costs you money.

So, again, do not risk your home, your savings, everything for which you have worked. A disgruntled patient is always a potential plaintiff. Keep him happy!

823 *Atlantic Avenue*
Long Beach, California

Not All Banks Are Insured



Insurance is compulsory only for certain institutions. In case of default, is your account protected?

BY ERNST I. CAHN*

IT IS SURPRISING to learn that after seventeen years of insurance of bank accounts, a tremendous amount of ignorance still exists on this matter. Most people consider it superfluous that a bank or a savings institution includes in its advertisements the remark that it is a member of either the Federal Deposit Insurance Corporation or the Federal Savings and Loan Insurance Corporation; they assume that it is compulsory for all financial institutions to have their accounts insured up to $10,000.

However, this is a positively inaccurate assumption. The only institutions that must carry insurance of accounts are Federal Savings and Loan Associations and those banks that are members of the Federal Reserve System.

The following facts are revealed in the annual report of the Federal Deposit Insurance Corporation to Congress as of December 31, 1950: Of the 14,164 commercial banks and trust companies, accounts in only 13,446 were insured. There existed at the same time 529 mutual savings banks in the United States but of these only 192 had their accounts insured by this corporation.

As of the same date there had been in existence 5,947 Building, Savings, and Federal Savings and Loan Associations. Of these, only 2,860; namely, all the 1,526 Federal Savings and Loan Associations and 1,334 Building, and Savings and Loan Associations operating under state, not federal, charter, were insured by the Federal Savings and Loan Insurance Corporation.

Thus, it is obvious why banks

*Consultant on insured investments

and savings institutions stress their membership in one of the above two insurance corporations. If institutions fail to do so, it is safe to assume that accounts with them are not insured.

The importance of the insurance for the owner of a bank account or a savings account is proved by the fact that, according to the forementioned report of the Federal Deposit Insurance Corporation, 415 insured banks became insolvent during the period between 1934 and 1950. All these institutions had been both under the supervision of the various state banking departments and under the jurisdiction of the Federal Deposit Insurance Corporation. These added safeguards did not prevent their default. However, because these banks were members of this insurance corporation, none of the owners of insured accounts was affected by the insolvencies. The Federal Deposit Insurance Corporation, in fulfillment of the insurance obligation, reimbursed the 1,354,000 depositors fully in the total amount of $273,000,000.

Although more than a year has passed, it is still generally unknown that on September 21, 1950, Congress had changed the mode of settlement making it identical for the Federal Deposit Insurance Corporation and the Federal Savings and Loan Insurance Corporation. (Law #S-822)

Under the new law it makes no difference whether an account is in an institution insured by the Federal Deposit Insurance Corporation or the Federal Savings and Loan Insurance Corporation. In case of default of an institution, both corporations either will pay the balance of the account in cash to the account owner or will transfer his account to another insured institution where he can obtain his funds on request.

This new law is a simplification and improvement. It will help to remove erroneous impressions as to the comparative standing of the two insurance corporations which were caused by the previous complicated and confusing procedures.

29 Broadway
New York 6, New York

"EDENTULOUS—?"

A MEDICAL report of a Middlesbrough, England, citizen had everyone in the local court guessing. The report said the man's health was perfect except for the fact that he was edentulous. "What does 'edentulous' mean?" asked the judge. No one knew. So the court's clerk was dispatched with a note to the public librarian, asking for an explanation. Back came the reply: "Edentulous—having no teeth."—*Chicago Tribune.*



Dentists in the NEWS

St. Paul (Minnesota) Pioneer Press: Doctor Arthur Alexander Van Dyke has held the St. Paul postmastership longer than any of his predecessors and, in addition, he is a dentist by profession, a dairy farmer by desire, and a politician by family tradition. And, he has made good in each field.

Since the beginning of his term as postmaster in 1933, the post office receipts have grown from an annual three million dollars to three times that much. Twenty-three years ago, Doctor Van Dyke started his dairy farm with seventy-three acres of land and three cows; today he has more than 900 acres and 200 head of purebred cattle. He enjoyed a successful dental practice until it was necessary to devote his full time to the duties of postmaster. After World War I, in which he served in the Army, Doctor Van Dyke took an active part in American Legion activities and played a prominent role in both Ramsey County and state Democratic politics.

Long Island (New York) Sunday Press: To prove that age is no barrier to what he considers a lost art, 56-year-old Doctor Isidore Bloom recently competed in the Joe Labowsky Memorial Walk, a ten-mile heel and toe race from Astoria to Long Island City. The Bronx dentist, who was the 1941 winner, came in tenth out of thirty-seven contestants and won the first "Old Boy" trophy. He finished in one hour and forty-seven minutes.

Doctor Bloom has been walking competitively for twenty-five years and plans to go right on, for he believes there is nothing like it for toning up the body. The athletic dentist is also an annual participant in the City Hall-Coney Island walking race, as well as the Atlantic City Boardwalk race. He keeps in practice by walking frequently from his home at 2561 Young Avenue in the Bronx to Times Square, a matter of thirteen miles. In addition to his heel and toe competition, Doctor Bloom plays tennis, ice skates, roller skates, and does some cartooning.

Kansas City (Missouri) Times: If it wasn't for the skill of an Army dentist in North Korea, it is possible that the first American wedding north of the thirty-eighth parallel could not have taken place. In the "church"—a tent on a North Korean hillside—Lieutenant Madeline Quinn, an Army nurse from Seattle, Washington, was married to Lieutenant Robert G. Lawson of Seneca Falls, New York. Next to the bridegroom, the proudest man in the church was Major Albert J. Di Matteo, a dentist from Jackson Heights, New York; he had made the wedding ring out of old gold "fillings."

Philadelphia (Pennsylvania) Inquirer: Doctor John A. Flood, dentist and burgess of New Hope, Pennnsylvania, set out recently on what promised to be one of his more pleasant official duties. He was to make a test collection of the borough's new parking meters. Only a few of the twenty-three meters to be installed were in operation but perhaps, Doctor Flood reasoned, the coins had already begun to accumulate. He had a key to the boxes and expectantly he opened the first one; it was empty. The second box revealed the same hollow condition. But the third coin box rattled and Doctor Flood eagerly tilted its contents into his

hand—only to find a single slug. The indignant dentist reported his find to the borough council which immediately appointed a retired New Hope businessman to be parking meter collector and vested him with authority to check the meters, warn motorists, and issue summonses to nonpayers.

Akron (Ohio) Beacon Journal: The new president of the American Society of Oral Surgeons, Doctor William T. Ewing, in partnership with his brother, Doctor Joseph Ewing, heads one of the largest private-practice oral surgery clinics in the country. Professional men from all over the continent stop in to watch the procedures in his clinic which keeps six dental surgeons, twelve nurses, and ten other staff members busy in their new Bowery Street building. The clinic is unique in that its combination of skills enables it to handle everything from extractions to correction of cleft palates.

Native political talent and leadership ability have brought Doctor Will Ewing through the various committee offices to the presidency of the American Society of Oral Surgeons. He is regarded highly in Akron for his generous help to young men getting started in dentistry.

Denison (Texas) Herald: An Independence, Louisiana, farmer unconsciously started a dentist in the business of mask-making when he asked him to fashion him a plastic nose. The farmer had suffered a disease that had destroyed his nose. Using another Independence patient as a model, Doctor M. T. Marietta molded a plastic mask to be attached to the farmer's face by metal hooks fitting inside the cheek bones.

From this, Doctor Marietta, who now lives in Dallas, Texas, developed plastic face masks to protect the noses and teeth of the entire Texas A & M football team. Coach L. R. Meyer of Texas Christian University describes the masks as "a fine contribution to football."

Doctor Marietta has turned his home into a mask factory, where he has made as many as fifty-three in one day. Football players throughout the country are enthusiastic about the mask for, while it protects the nose and teeth, it does not obstruct the vision.

Omaha (Nebraska) World-Herald: Living within a fifty-mile radius of the geographic center of the United States for seventy-five years has not limited the activities of Doctor Elmer Alonzo Thomas of Hastings, Nebraska. His career began when, as a Webster County farm boy, he worked as a medical assistant at the Hastings Asylum for the Incurable Insane. His shock at the lack of dental care and general abandonment of these patients by family and society led to his decision to study dentistry. He hoped that dental treatment might provide some help for the neglected inmates.

Specializing in oral surgery, Doctor Thomas became recognized in and beyond Hastings as one of the foremost investigators of the relationship of dental disorders to mental ills and criminology. He worked incessantly to raise the standards of health at the Hastings asylum. Finally, Doctor Thomas closed his Hastings office and spent his full time at the State Hospital, even donating equipment to the institution. Now, fully retired, the Nebraska dentist has a dental chair in his home where he limits his practice to members of his family.

Tupelo (Mississippi) Daily Journal: Six Tupelo dentists have been commended for their service through the year-old program of free dental care for underprivileged children of Lee County. The dentists taking part in this plan are Doctors W. L. Stroup, T. L. Morgan, Charles Nash, Ozie Drummond, Bryson Shirley, and E. M. Topp. Cooperation between these dentists, the health department, the Tupelo Service League, and the county welfare department has provided dental examinations for over a hundred needy children during the last

year. Children found to need treatment are given an appointment with one of the six dentists who serve them free of charge. The plan has been cited as a real step in the prevention of socialized medicine.

Cleveland (Ohio) Plain Dealer: At the annual autumn council of the Seventh Day Adventists held in the Hotel Hollenden in Cleveland recently, 500 world leaders of the church voted for an appropriation of $750,000 for a school of dentistry to be operated by the church. The initial step in a $5,865,400 expansion program for the church's medical facilities, the dental school will be a section of the Loma Linda, California, division. As a part of the denomination's College of Medical Evangelists, the proposed dental school is expected to accommodate forty-eight students.

Gastonia (North Carolina) Gazette: The Tiny Tim Society, a group of people who work in the interest of crippled children at the North Carolina Orthopedic Hospital, has presented a plaque to the hospital in memory of Doctor Daniel Edward McConnell. This prominent Gastonia dentist, who died in 1950, served devotedly for many years as dentist to the children of the hospital. Funds left over after the purchase of the plaque were used to buy additional dental equipment for the Orthopedic Hospital.

Awards for items published in this month's DENTISTS IN THE NEWS have been sent to:

Mrs. Josephine Peters, Box 275, Scribner, Nebraska.
Mrs. Gertrude Wells, 431 Talbert Street, Tupelo, Mississippi.
Mrs. Carl Ware, Route 2, Bessemer City, North Carolina.
Adeline E. Cohen, Box 125, Uptown Station, St. Paul 2, Minnesota.
George B. Fritz, 207 Logan Avenue, Bedford, Ohio.
Mrs. Henry T. Henson, Route 2, South Main Street, Wadsworth, Ohio.
William G. Holmes, D.D.S., Medical & Surgical Clinic, Denison, Texas.
Mrs. J. W. Blackmer, 918 Cherry Street, Kansas City 6, Missouri.
Isidore Bloom, D.D.S., 2561 Young Avenue, Bronx 69, New York.

CAN YOU USE A DOLLAR?

TO EVERY READER who contributes a newsworthy item, something unusual about a dentist, *which is published in Dentists in the News,* we will send promptly a crisp, new one-dollar bill. Every clipping must be taken from a newspaper and carry the name of the publication and the date line. Clippings submitted cannot be returned. When more than one copy of a clipping is submitted, the first one received will be used. Send all items to Dentists in the News, ORAL HYGIENE, 708 Church Street, Evanston, Illinois.

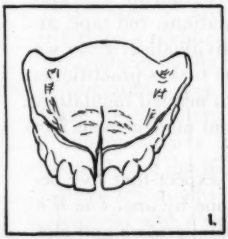
TECHNIQUE of the Month

Conducted by W. EARLE CRAIG, D.D.S.

Drawings by Dorothy Sterling

Prevention of Recurring Palatal Fractures in Acrylic Dentures

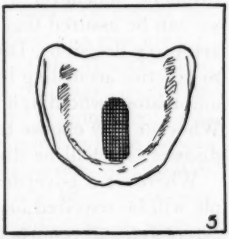
BY PATRICK F. PHELAN, D.D.S.



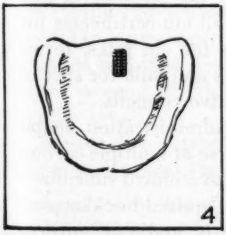
A palatal fracture in an acrylic denture is likely to recur unless the repair is reinforced successfully.



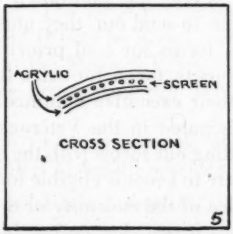
Especially good reinforcement is furnished by a piece of stainless steel or chrome cobalt screen.



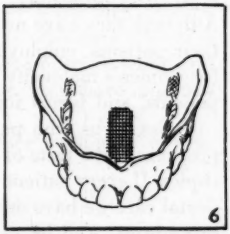
For midline fractures, place the screen just posterior to the centrals. It should be about half the length of the palate and about as wide as the two centrals.



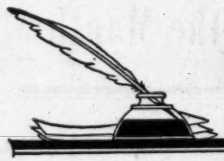
For other types of fracture, use a smaller piece of screen and center it over the fracture line.



Use care to have the screen completely embedded—centered in the thickness of the acrylic.



Result is a sturdy repair that will withstand all normal stress.



EDITORIAL COMMENT

"Give me the liberty to know, to utter, and to argue freely according to my conscience above all liberties." *John Milton*

BY-PRODUCTS OF SOCIALIZED HEALTH CARE

ONE ASPECT of compulsory health insurance that has received little attention is the effect of such a system on the morale and efficiency of practitioners. Whenever a government undertakes a program of any kind, we can be assured that it will be smothered in regulations, red tape, and arbitrary decisions. Diagnostic and therapeutic individualism gives way to practice according to the rule book. Such a system makes practitioners automatons who diagnose and treat cases in line with printed regulations. Whoever may choose to show individualism in patient management faces disaster. He will be disciplined or refused payment.

Wherever a governmental agency exists we may expect that five people will be required to do the work that might be done by one. *The Wall Street Journal* reports that in Great Britain the administrative and clerical staff of one London hospital jumped from 40 to 200 under socialized medicine.

We can also be sure that under compulsory health insurance dentists and physicians are required to spend as much time with pen and pencil as they do with a dental handpiece and stethoscope. According to *The Wall Street Journal*: "Red tape has multiplied for the physicians, too. Although they have no bills to send out, they must fill out certificates for their patients' employers, forms for coal priorities for old folks, forms for women's maternity benefits, forms for extra fruit and milk for special patients, and forms for their executive administrative councils."

Those of us who participated in the Veterans Administration dental program had a taste of filling out forms with the curse of multiple carbon copies. If *every* patient were to become eligible for government subsidized dental care we have an idea of the enormity of the required bookkeeping procedures. And let us not forget that review boards, auditors, government snoopers, would be a part of the compulsory health insurance system as they are now part of other governmental agencies.

Neither has the subject of age been given enough discussion in plans

for socialized health service. By consulting a table of organization, a bureaucrat sitting in Washington would determine at what age dentists throughout the country were qualified for certain positions in the health service. Is this practice followed in England under the National Health Service? It is. Here is what the *British Medical Journal* says on this subject:

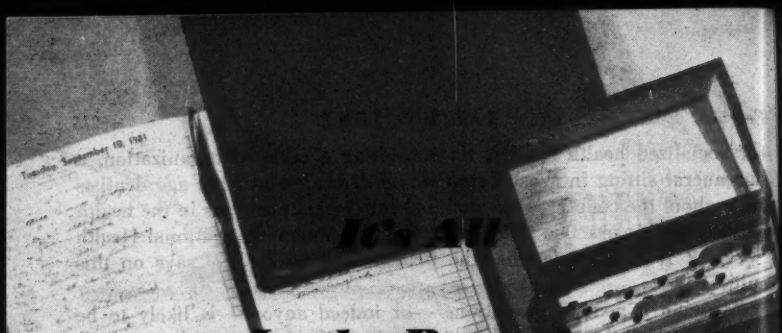
"Though a general practitioner—or indeed anyone—is likely to be a wiser man at the age of 40 than he was at 25, some executive councils seem to think otherwise. Sometimes a physician's age alone has deterred executive councils from appointing him to a vacancy, and according to the Medical Practices Committee one executive council 'eliminates without further consideration all candidates above 40 years of age.' The difficulties of entering general practice are great enough without a candidate's being penalized for his age and spurned for the experience that goes with it. If this kind of policy ever became widespread it would be almost impossible for a middle-aged physician to start practicing in a new area.

"In response to the discovery that this was going on, the Medical Practices Committee recently sent a letter, from which the above quotation is taken, to executive councils, drawing attention to a number of facts that should already have been uppermost in the minds of the people responsible for the local administration of general practice. As it points out, there are good physicians aged 60-65 or less who have no regular employment and no prospect in such a system of obtaining it. Despite repeated applications for advertised vacancies they fail to obtain a place on any short-list. Many of the vacancies have been of moderate size and well within the capacity of such physicians. There are also elderly physicians in large industrial practices looking for modest vacancies in more pleasant areas. They are entitled to some consideration in their efforts to go to less strenuous practices, as men in their position often did before the Health Service started. The large practices they leave then become available for younger men. It is to be hoped that the offending executive councils will take heed of the Medical Practices Committee's letter and cease to send physicians begging merely because they have attained middle age."[1]

Present-day corruption in government is another reason to oppose the governmental regulation of health services.

[1]Editorial: Not Too Old at 40, British Med. J. **4739**:1078 (November) 1951.

Edward J. Ryan



It's All In the Records

This adaptable plan of dental office operation nets maximum efficiency with minimum detail.

BY SYLVIA DANENBAUM

THE PRACTICAL approach to keeping records in the dental office is to keep only those records which are necessary to the practice, remembering that what is significant in one office may be insignificant in another. Select only what is important to your particular needs.

The basic elements of a simple, workable, easy-to-follow record system consist of:

1. *The appointment book,* which can double for a day sheet. Besides noting the daily appointments, indicate after each patient's name the service rendered and any payment made at the time such service is rendered. This information is transferred later to the patient's record card.

2. *The patient's individual record card,* on which is itemized the complete history of the case, including charges and payments.

3. *A looseleaf notebook with hard cover,* the size to hold 8½ by 11-inch ruled paper. In this book are kept several record sheets to place pertinent information within easy reach at all times and, most important, to prevent losing sight of the patient. These sheets are:

(a) *The collection list:* When a bill for services is rendered, the name of the patient is placed immediately on this list together with the amount due. When payment is made, the name is crossed off. This sheet keeps the accounts due always in sight in a concise, easy-to-read form. It is a constant re-

minder, as well, of outstanding accounts and a prod to keep after delinquents. Also, the list prevents a slip-up when sending out statements each month, because a quick glance shows up names you could otherwise forget if you had to search through individual record cards. All notations appearing against the names on this list must appear on the patient's own card as well.

(b) *The recall list:* On this sheet are listed the names and addresses of patients desiring recall for examination and prophylaxis. It is indexed by months, a separate page for each month. At the time of the patient's final visit, his name is entered on the list for the month in which he is to be recalled. When the patient reports, his name is crossed off and notation made on his card. Should he not reply to the first reminder, his name is carried to the next month's list. After two notices without response, his name is placed ahead for re-recall in three months. On this sheet, too, are listed the names of patients who have discontinued treatment or have broken appointments, and could not be reached immediately. Both categories are marked for notification later in the current month or in the following month. In this way, they are not lost in the shuffle.

(c) *The telephone list:* On this sheet appear the names of those patients who can be reached by telephone to come in on short notice. The owner of a one-man business and a shopkeeper, for example, who have difficulty planning ahead to get away from their business places, are grateful for a call to fill an appointment cancelled by another patient—a saving of time for both patient and dentist.

(d) *The cash sheet:* On this sheet are entered daily the money taken in and the cash paid out. The checkbook will show expenditures paid by check. At the end of the month these figures are transferred to a yearly summary, recorded by months, and thus show expenses and receipts for the year. On this sheet, provision can also be made to record withholding and social security taxes.

These simple record sheets eliminate the need for an assortment of ledgers, and do away with the necessity of thumbing through the file of patients' record cards over and over again to check payments, to find recalls, or to determine follow-ups. And, since the name of each active patient must appear on one of these lists, the most important function of all is carried out—the possibility of losing track of the patient is reduced to a minimum.

700 *West* 175*th Street*
New York 33, *New York*

Q ASK Oral Hygiene A

Please communicate directly with the department Editors, V. Clyde Smedley, D.D.S., and George R. Warner, M.D., D.D.S., 1206 Republic Building, Denver, Colorado, enclosing postage for a personal reply.

Mucoid Deposits

Q.—Two years ago I constructed a full upper and partial lower denture for a man about 50 years of age. The surgeon who extracted the teeth did a fine job and apparently I was able to construct the upper denture in a satisfactory way. However, the patient returned saying that as soon as the dentures were in his mouth for a few minutes a slimy substance would form under the dentures. They would gag him unless he removed them and cleaned them. When I would insert the dentures they would be exceptionally tight. He is quite cooperative, and at his suggestion I rebased the dentures, but the results are the same. As for the fit, I do not believe it can be improved.

He complains of this sliminess entering at the anterior and working slowly back. The anterior ridge is slightly spongy, but by no means excessive. He has the feeling that this substance is a secretion of the gingivae, but this hardly seems possible.

Now he wonders if a new set would be any better. I do not feel he should spend additional money. I do not believe it would help. If you can be of any help to me, I certainly should appreciate it.—R.L.G., Pennsylvania.

A.—The best solution I know of for this difficulty is for the patient to develop the habit of sucking and swallowing as often as may be necessary to prevent excess mucous or saliva from accumulating above the denture.—V. Clyde Smedley.

Cervical Adenitis

Q.—I have a patient who is having pains in the area of her lower third molar, down into the glands of her neck and throat, and a great deal of pain in the sternocleidomastoid muscle. The glands cause her much discomfort, especially at night. This is not a case of infected teeth or a third molar condition. Her mouth is in a clean and healthy condition. The bite is normal with a small amount of wear causing the upper anteriors to be worn some from the lowers.

I would judge that the amount of wear has nothing to do with the condition; however, she was sent to an eye, ear, and throat specialist who said her difficulty was caused by the closing of her bite from wear. But he could not tell her why she has pain around the gingival tissue or in the lower third molar area, nor why she has no pain in the ear or temporomandibular joint. She has no pain above the occlusal plane of her teeth; it is all in the neck and up to the teeth in the lower jaw. She is a hypersensitive person and her teeth used to be sensitive at the gingival area. But, of late, she does not complain much about this condition.

If you think that you should have more history on the case, I would be glad to inform you.—F.F.T., Nebraska.

A.—The symptomatology of the case cited in your letter is not, so far as my experience goes, that of loss of vertical dimension, but rather of cervical adenitis. If your diagnosis of the oral conditions is correct; there are no embedded,

impacted, or infected teeth or disease of the alveolar bone; the case is not dental and should be in the hands of an internist.—GEORGE R. WARNER.

Iron Medication

Q.—I should appreciate it if you could tell me if there are any harmful effects to the teeth, other than staining, when a person takes a medicine containing iron.

I have had patients tell me that their teeth deteriorated after taking iron medicine; however, I was never convinced this was the true reason.—D.S., Pennsylvania.

A.—From a knowledge of the chemistry of the various forms of iron used in medication for anemia as well as quite a wide experience in its use, I believe it can be said safely that iron does not have any destructive action on tooth enamel nor on the supporting structures of the teeth.—GEORGE R. WARNER.

Gagging

Q.—I have a patient, about 45. Her teeth were extracted recently, and I am trying to restore them. I had trouble taking the impressions, but finally managed to get good ones. I have made several attempts to try the bite plates in but she cannot keep them in her mouth long enough to permit me to take the bite. I thought it was her tonsils which caused her discomfort and gagging, and I still think so; but my laryngologist says it is her tongue. I cut the roof out of the upper denture (try-in plates) but still do not have any success with it. By using topical anesthetic on her tongue and tonsils, I have obtained much better results with the lower denture.

Will you please tell me how to overcome this difficulty?—F.C.C., North Carolina.

A.—I find that dissolving an Abbott's A. C. Troche on the base of the tongue will permit me to work in such a mouth. Doctor Warner uses the Mann topical anesthetic (which is effective and faster) for his roentgenograms. If you can finish the dentures to provide a firm postdam to prevent the tickling action of a make and break of contact as the soft palate flexes in function, with reasonable effort on the patient's part she should be able to wear the dentures. Occasionally, I have satisfied stubborn gaggers by the placing of roofless upper dentures.—V. CLYDE SMEDLEY.

Anterior Abrasion

Q.—I am sending models showing extreme erosion of the anterior teeth of a man, age 44. As the teeth have abraded, it seems the mandible has gone into protrusion, and the bite has closed so that with his jaws closed he appears to be edentulous. There are no caries, no restorations, and the gingivae seem to be in good condition. Can you suggest any correction for this case?—O.A., Indiana.

A.—We have seen and cared for a number of similar cases where the anterior teeth show considerably more abrasion than the posterior, but this I believe is the most extreme of them all.

Our orthodontist friend, Doctor William R. Humphrey, has been successful in treating this type of malocclusion in young people, be-

(*Continued on page* 222)





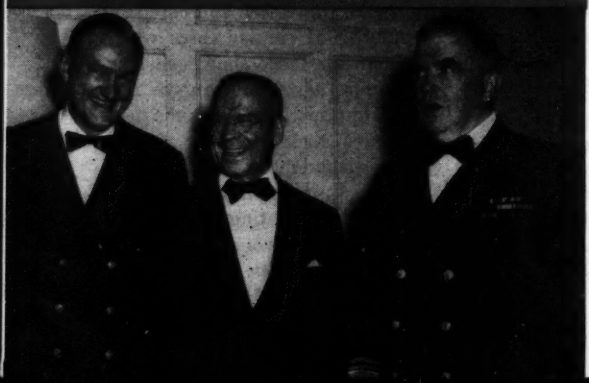
Left: Wash Acad Hunt Alab emy.

Righ gome Acad hono

Portraits and Profiles of American Dentists

By Howard A. Hartman, D.D.S.

Below: Left to right: Captain Clay A. Boland, (DC) USNR; James E. Algeier of Philadelphia, President-Elect of the Academy and Admiral Alfred W. Chandler, (DC) USN.



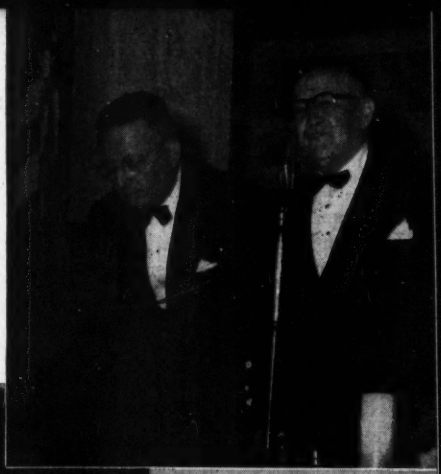
Above left: show the Meeting of American Dental sociation in W ington are (left right): James Lucas, Wichita, K sas; David J. gibbon, Washing D. C.; and Fre Richmond, Ka City, Kansas.

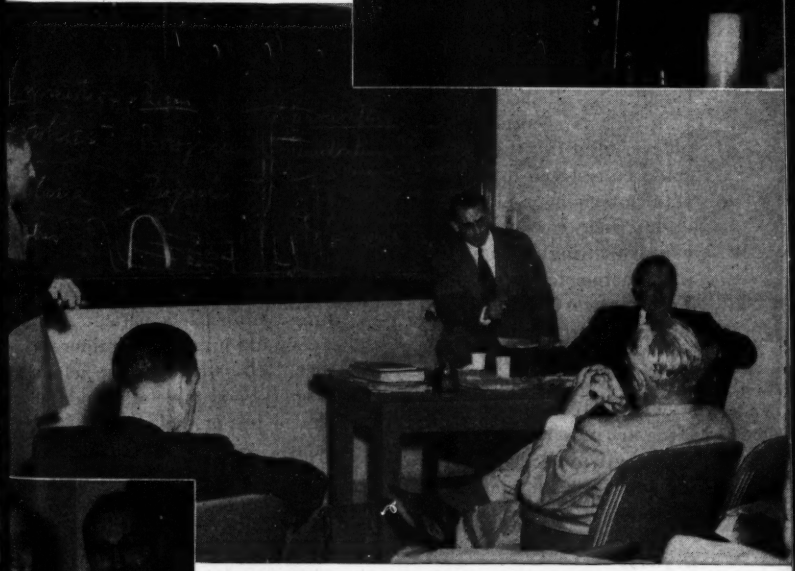
MEETING OF AMERICAN ACADEMY OF PERIODONTOL WASHINGTON,

Right: Violetta boleda, dentist f Cali, Colombia, received her M.S. gree in periodo ogy from Tufts lege recently; Irving Glick Dean of Tufts lege of Denti Boston.

Left: Mildred W. Dickerson of Washington, D.C., Co-Chairman of Academy Round-Table Forum; and Hunter S. Allen of Birmingham, Alabama, President of the Academy.

Right: Olin Kirkland of Montgomery, Alabama, addresses the Academy following his receipt of an honorary fellowship in the group.







Above: Representatives of the American Academy of Oral Pathology and the American Academy of Periodontology met at Walter Reed Hospital prior to the American Dental Association meeting to attempt to clarify the nomenclature and classification of periodontal disease. Shown at this discussion are: Colonel Joseph L. Bernier, (DC) USA (standing); Lent C. Johnson, Chief, Section of Orthopedic Pathology, Armed Forces Institute of Pathology; and Harold G. Ray of San Francisco (facing camera, right).

(*Continued from page* 219)

fore such radical abrasion occurred, by fitting them with plastic appliances that support the occlusion on the anterior teeth and throw the posterior teeth out of occlusion. It is surprising how much these posterior teeth will elongate in just a few months if they are held constantly out of occlusion.

Obviously, this patient needs his bite opened. This could be done by lengthening all the posterior teeth with crowns or occlusal inlays or onlays. After this the anterior teeth could be restored to normal length with porcelain or plastic crowns.

But first, I would suggest that you try fitting the anterior teeth with tooth-colored acrylic splints. You can carve these in wax to simulate normal tooth form, process them in acrylic, and cement them on over the worn stubs of his own teeth. If the posterior teeth do elongate into occlusion, you can place individual plastic crowns on the anterior teeth later.—V. CLYDE SMEDLEY.

Dryness

Q.—I have a patient about 40 years old, for whom I made dentures. When taking the impressions, the flow of saliva was great, but when the patient wears the dentures, her mouth becomes so dry she can hardly swallow. I have never heard of such a case. Can you suggest a remedy?—C.E.E., New Mexico.

A.—Neither Doctor Warner nor I have ever heard of a similar case. It is not unusual for the flow of saliva to be greatly increased temporarily following the insertion of dentures, but I have no idea why the insertion of dentures would cause a copious flow to cease unless it is purely psychologic. I would certainly expect the condition to be temporary.—V. CLYDE SMEDLEY.

Loose Dentures

Q.—I have a patient, a healthy woman of about fifty for whom I have made dentures. I have made dentures for her four separate times, and each time, after a period of six months, she loses all suction. The last set was made only three months ago.

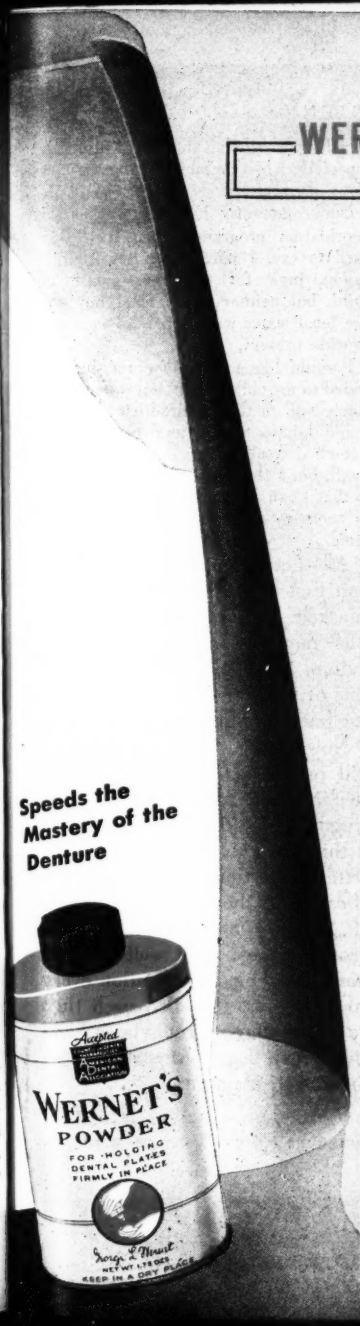
I shall appreciate any help that you can give me.—G.I.B., Ohio.

A.—There are a few patients whose denture-supporting ridges just seem to melt away under dentures. For such a patient, I think we should prescribe a mineral-rich diet. Milk, whole grain, kelp, and ground bone tablets should be included in her diet. Such a patient should be encouraged to learn to wear loose dentures or even, in such an extreme case as this, to resort to adhesive denture powder to postpone rebasing or replacing with new dentures quite so often. —V. CLYDE SMEDLEY.

Sulfathiazole Dusting

Q.—A woman patient, 44 years old, presented herself for extraction of a loose pyorrhetic upper right second bicuspid. A roentgenogram was taken and buccal and lingual infiltration was made. It was a simple extraction, followed by

(*Continued on page* 226)



WERNET DENTAL LORE

FEBRUARY 1952

Increased military needs have pointed up the desirability of accelerating dental education. The 1950 undergraduate enrollment (11,891 students) in the country's 42 dental schools represents an increase of nearly 64% over the 1945 registration. And, while two schools have shortened their program to three years, and one is optionally shortened, 39 of the schools still maintain their 4-year curriculum.

• • •

Vital statistics: In 1949, the average dentist worked 33 hours per week at the chair, and 5 hours in the laboratory. He saw more female patients than male, at every age level. He did more extractions on males than on females, and supplied more *upper* dentures for males ... but (oddly enough), more *lower* dentures for females.

• • •

While the country's dental schools are admitting an ever-increasing number of new students, they are not neglecting provision for advanced studies at the same time. This is reflected in the 1950-51 enrollment of 2,679 graduate, postgraduate and special students, as compared (for instance) with 3,226 freshman students.

• • •

Early American progress in prosthetics is reflected by newspaper advertisements of the time. In 1749, a Parisian dentist, Roquet, announced in Boston that he drew decayed teeth and substituted "an entire Sett of right African Ivory Teeth"; and in 1761, Hugh Tomb, M.D., of Philadelphia, professed to render the same service.

• • •

The periodic, scientific slashing of the Sterculia species of tropical shrubs and trees in India increases the natural production of their exudate, karaya gum, which forms so important a part of Wernet's Powder.

(*Continued from page* 222)

dusting with sulfathiazole powder.

Three days later the patient presented herself with purple discoloration of the right ear. I sent her to her physician. A short time later, paralysis of the facial nerve took place and the patient was hospitalized by her physician.

Now she is suing me for using sulfathiazole dusting without asking her if she were sensitive to the drug. I neglected to inquire. She tells me now that she had a history of being sensitive to this drug a few years before.

Could dusting the wound cause all her trouble or is the paralysis incidental? Any references you can give me concerning dire results of sulfa dusting would be appreciated.—H.H.S., New Jersey.

A.—We know of no reference in dental or medical literature descriptive of dire results from sulfathiazole dusting. The worst results recorded are a temporary skin rash or local mucous inflammation or congestion.

It is difficult to believe that you could be held guilty and liable for damages. However, anything can happen in a court trial, so if you do not carry liability insurance, it would be advisable for you to employ the best attorney available.—V. CLYDE SMEDLEY.

Fluoridation

Q.—Fluoridation of community water supplies to the extent of 1.2 parts of sodium fluoride to a million parts of water has been proved effectively to be of value in reducing the extent of caries especially when ingested during the first eight years of life.

Our community here as yet has no fluoridation program. When it will is hard to say. I purchase water in five-gallon jugs for my three-month-old child, but neither the water I buy nor our local water supply has any natural fluoride present.

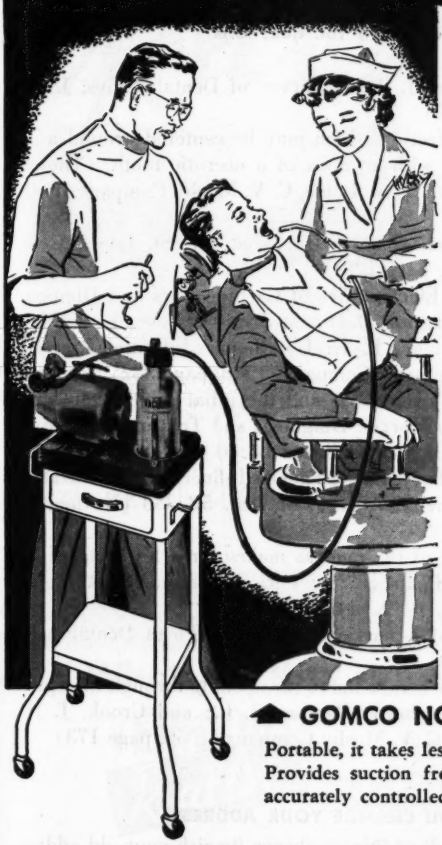
I would like to have sodium fluoride added to my child's drinking water. How much NaF to the hundredth of a grain would I have to add to five gallons of water? I realize the amount will be small, but I should like this information so that I can get started on the program as soon as possible.—C.F.L., Pennsylvania.

A.—Let me answer your question first and then give you some unasked advice. My pharmacist tells me that one-half grain of sodium fluoride added to five gallons of water will give a little over one part per million.

Now, your three-month-old child will receive no protection against dental caries drinking fluoride impregnated water. When the child is three years old you can give it better protection for the incidence of caries by the topical application of 2 per cent sodium fluoride. From that age until well into the teens, the topical application every three months, preceded each time by a thorough prophylaxis, will give a high degree of protection.—GEORGE R. WARNER.

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SO YOU KNOW SOMETHING ABOUT DENTISTRY!

ANSWERS TO QUIZ LXXXIX

(See page 195 for questions)

1. (b) 65 per cent. (Lane, J. R.: A Survey of Dental Alloys, JADA **39**:414 [October] 1949)
2. A retained focus of infection which may be centered around a sequestrum or connected with an apex of a necrotic tooth. (Thoma, K. H.: Oral Surgery, Vol. 2, St. Louis, C. V. Mosby Company, 1948, page 915)
3. (a), (b), both. (Sicher, Harry: Oral Anatomy, St. Louis, C. V. Mosby Company, 1948, page 128)
4. True. (Larson, N. H.: Efficient Use of Carbide Burs and Diamond Points for Cavity Preparation, D. DIGEST **55**:495 [November] 1949)
5. (b) decreased. (Grossman, L. I.: Handbook of Dental Practice, Philadelphia, J. B. Lippincott Company, 1948, page 382)
6. Because of the flat broad contacts and the usual small occlusogingival distance. (Kelner, Morris: Diagnosis and Treatment Planning for the Juvenile Patient, J. Den. Children **16**:30 [3rd Quarter] 1949)
7. (a) endogenous. (Newbury, C. R.: Factors Influencing Colonization of Bacteria in Oral Cavity, Aust. J. of Den. **53**:338 [November] 1949)
8. Yes—continued drying of the mucosa makes for a lowering of the tissue resistance. (Goldman, H. M.: Periodontia, ed. 2, St. Louis, C. V. Mosby Company, 1949, page 341)
9. True. (Accepted Dental Remedies, ed. 16, American Dental Association, 1951, page 139)
10. No—the current may be conducted to the opening through the apical foramen. (Gottlieb, Bernhard; Barrow, S. L.; and Crook, J. H.: Endodontia, St. Louis, C. V. Mosby Company, 1950, page 173)

WHEN YOU CHANGE YOUR ADDRESS

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LAFFODONTIA

The cavalry recruit was instructed to bridle and saddle a horse. Ten minutes later the sergeant-major came along for his mount and found the recruit holding the bit close to the horse's head.

"What are you waiting for," he roared.

"Until he yawns," answered the recruit.

★

Mrs. Browning: "Do you think I am going to wear this old squirrel coat all my life?"

Browning (brightly): "Why not, dear? The squirrels do."

★

She: "Oh, Mr. Blanks, I suppose you actors hate boos more than anything else."

Actor: "Well, madam, it all depends on how you spell it."

★

Oscar came to the city and got a job as janitor in a girls' boarding school, and was entrusted with a pass key to every room in the building.

The following week the dean ran across him and asked, "Why didn't you come around Friday for your pay, Oscar?"

"Vot! Do I get vages, too?"

★

"Conductor, will you help me off the train?"

"Sure."

"You see, I'm stout, and have to get off the train backwards; the porter thinks I'm getting on and gives me a shove on again. I'm five stations past my destination now."

Teacher: "Now, Carol, what is a niche in a church?"

Carol (fidgeting): "Why—uh—it's just the same as an itch at home, only you can't scratch it as well."

★

Sunday School Teacher (talking about God): "Nobody ever has seen Him."

Small Scholar: "My Daddy knows where God is. Every morning he pounds on the bathroom door and says, 'My God, are you still in there?' "

★

"Well, Dad, I just ran up to say hello."

"Too late, son. Your mother ran up to say good-bye and got all the change."

★

Bill: "How did you come through the Depression—did you suffer much?"

John: "Did I! The seat of my trousers became so thin I could tell when sitting on a dime whether it was heads or tails!"

★

Boss: "Where have you been?"

Employee: " 'Avin me 'air cut."

Boss: "You know you can't have your hair cut on company time."

Employee: "Well, it grew on company time, didn't it?"

Boss: "Not all of it."

Employee: "Well, I ain't 'ad it all cut off."

★

Admirer: "What a charming necklace!"

Film Star: "Yes, isn't it adorable? Made entirely of my wedding rings!"